# 2018 BCBSIL PPO BENEFIT PLAN SUMMARY

| Benefit | *BCBSIL PPO Network | *BCBSIL PPO Out-of-Network |
|---|---|---|
| Deductible, Co-Insurance and Calendar Year Out-of- Pocket Limit<br><br>Note: The deductible is included when calculating the annual out-of-pocket limit. | $400 individual annual deductible ($800 family), then plan pays 85% of eligible charge. Calendar year out-of-pocket limit for in-network expenses of $2,800 for single, $5,600 for single plus one, and $8,100 for family, then plan pays 100% for the remainder of the calendar year. | $400 individual annual deductible ($800 family), then plan pays 70% of eligible charge. Calendar year out-of-pocket limit for out-of-network expenses of $3,100 for single, $6,200 for single plus one, and $9,000 for family, then plan pays 100% of eligible charges for the remainder of the calendar year. |
| Preventive Care Services | Includes general health screenings for newborns, children and adults, immunizations, cancer screenings, health counseling and women's preventive services. Covered at 100% with no deductible or co-insurance when in-network provider is used. | Most Preventive Care Services are not covered if out-of-network provider is used. The exception is for well child care up to age 3, well-woman exam with pap and mammogram, prostate screening exam with PSA test, fecal occult blood test for colorectal cancer screening, and HPV vaccine. The plan will pay 70% of the eligible charge after deductible. |
| General Hospital Admission, In-Hospital Services, Supplies and Anesthesiology | 85% of eligible charge after deductible. | 70% of eligible charge after deductible. |
| Blue Distinction Centers (BDC) and Blue Distinction Centers + (BDC+) | 90% of eligible charge after deductible using a BDC and 95% of eligible charge after deductible using a BDC+ for certain specialty care areas. | Not applicable. |
| Out-Patient Surgery<br>In-Patient Surgery | 85% of eligible charge after deductible.<br>85% of eligible charge after deductible. | 70% of eligible charge after deductible.<br>70% of eligible charge after deductible. |
| Out-Patient X-Ray and Laboratory | 85% of eligible charge after deductible. If test is part of preventive care services, then it is paid at 100%. | 70% of eligible charge after deductible. If test is part of preventive care services, then may not be covered. |
| Emergency Care | 85% of eligible charge after deductible. | 85% of eligible charge after deductible. |
| Physicians Visits: In-Hospital, Office Visits, and Consultations | 85% of eligible charge after deductible. | 70% of eligible charge after deductible. |
| Chiropractic Visits: | 85% of eligible charge after deductible limited to 40 visits per calendar year. | 70% of eligible charge after deductible limited to 40 visits per calendar year. |
| Routine Vision Care | Not covered, but program through EyeMed or Davis Vision allows discounts on eye exams, glasses and contacts. | Not covered, but program through EyeMed or Davis Vision allows discounts on eye exams, glasses and contacts. |

| Benefit | *BCBSIL PPO Network | *BCBSIL PPO Out-of-Network |
|---|---|---|
| Home Health Care | 85% of eligible charge after deductible up to 40 days per calendar year. | 70% of eligible charge after deductible to 40 days per calendar year. |
| Skilled Nursing Facility | 85% of eligible charge after deductible up to 60 days per calendar year. | 70% of the eligible charge up to 60 days per calendar year. |
| Hospice Care | 85% of eligible charge after deductible. | 70% of the eligible charge after deductible. |
| Mental Health and Substance Abuse | 85% of eligible charge after deductible. | 70% of the eligible charge after deductible. |
| Pre-Authorization Requirement | Pre-authorization required prior to hospitalization or within 48 hours of emergency admission, skilled nursing or mental health/substance care treatment unless another plan is primary. | Pre-authorization required prior to hospitalization or within 48 hours of emergency admission, skilled nursing or mental health/substance care treatment unless another plan is primary. |
| **Prescription Drug Plan**<br>*Cost included with health care plan. Deductible and co-insurance maximums separate from Medical and Dental Plans.*<br><br>No deductible for prescription drugs. Annual out-of-pocket maximum for all drugs, including retail, mail order and specialty is $2,300/person, $4,600/ family. | **Generic Drugs:**<br>**30 Day Retail**: 20%<br>(minimum co-pay $10)<br>**90 Day Retail:** 20%<br>(minimum $25 maximum $85)<br>**Mail Order:** 20%<br>(minimum $20 maximum $75)<br>**Preferred Brand Drugs:**<br>**30 Day Retail**: 25%<br>**90 Day Retail:** 25% (maximum $115)<br>**Mail Order:** 25% (maximum $105)<br>**Non-Preferred Brand Drugs:**<br>**30 Day Retail**: 40%<br>**90 Day Retail:** 40% (maximum $155)<br>**Mail Order:** 40% (maximum $140)<br>**Specialty Drugs:**<br>**Specialty Pharmacy:** 20%<br><br>**Note: When a generic drug is available, participant must use generic or pay cost difference along with brand co-pay for both retail and mail order.** | N/A |

*In-network and out-of-network expenses will be applied equally toward the satisfaction of both the in-network and out-of-pocket maximums.